FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042333

Facility Name: WINFIELD HEALTHCARE CENTER

Address: 28W141 LIBERTY ROAD (Number) WINFIELD (City) 60190 (Zip Code)

County: DUPAGE

Telephone Number: (630) 668-9696 **Fax #** (630) 668-7078

IDPA ID Number: 364103122001

Date of Initial License for Current Owners: 08/31/96

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
		X	Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) DONALD MAGNUSON, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	125	Intermediate (ICF)	125	45,625	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	125	TOTALS	125	45,625	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	39,002	4,005	200	43,207	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	39,002	4,005	200	43,207	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.70%

D. How many bed-hold days during this year were paid by Public Aid?
1207 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/31/96

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/31/96 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified N/A and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	164,976	16,159	8,565	189,700		189,700		189,700			1
2	Food Purchase		193,067		193,067	(7,775)	185,293	(178)	185,115			2
3	Housekeeping	240,394	38,757		279,151		279,151		279,151			3
4	Laundry	29,718	29,638		59,356		59,356		59,356			4
5	Heat and Other Utilities			140,976	140,976		140,976		140,976			5
6	Maintenance	20,396	5,954	278,579	304,929		304,929	(114,446)	190,483			6
7	Other (specify):*											7
8	TOTAL General Services	455,484	283,575	428,120	1,167,179	(7,775)	1,159,405	(114,624)	1,044,781			8
	B. Health Care and Programs											
9	Medical Director			3,000	3,000		3,000		3,000			9
10	Nursing and Medical Records	1,129,530	33,274	7,116	1,169,920		1,169,920	(393)	1,169,527			10
10a	Therapy			5,196	5,196		5,196		5,196			10a
11	Activities	85,100	11,739	10,077	106,916		106,916		106,916			11
12	Social Services	125,466		7,531	132,997		132,997		132,997			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,340,096	45,013	32,920	1,418,029		1,418,029	(393)	1,417,636			16
	C. General Administration											
17	Administrative	108,126		383,433	491,559		491,559		491,559			17
18	Directors Fees											18
19	Professional Services			68,892	68,892		68,892	(7,084)	61,809			19
20	Dues, Fees, Subscriptions & Promotions			41,556	41,556		41,556	(8,659)	32,897			20
21	Clerical & General Office Expenses	24,436		111,959	136,395		136,395	(66,929)	69,466			21
22	Employee Benefits & Payroll Taxes			338,734	338,734	7,775	346,509		346,509			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,195	1,195		1,195		1,195			24
25	Other Admin. Staff Transportation			2,753	2,753		2,753		2,753			25
26	Insurance-Prop.Liab.Malpractice			41,055	41,055		41,055		41,055			26
27	Other (specify):*											27
28	TOTAL General Administration	132,562		989,577	1,122,139	7,775	1,129,914	(82,672)	1,047,242			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,928,142	328,588	1,450,617	3,707,347		3,707,347	(197,688)	3,509,659			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER #0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation							304,157	304,157			30
31	Amortization of Pre-Op. & Org.							2,393	2,393			31
32	Interest							321,596	321,596			32
33	Real Estate Taxes			47,185	47,185		47,185		47,185			33
34	Rent-Facility & Grounds			365,000	365,000		365,000	(365,000)				34
35	Rent-Equipment & Vehicles			19,803	19,803		19,803	(1,368)	18,435			35
36	Other (specify):*											36
37	**TOTAL Ownership**			431,988	431,988		431,988	261,778	693,766			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			68,438	68,438		68,438		68,438			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			68,438	68,438		68,438		68,438			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,928,142	328,588	1,951,043	4,207,773		4,207,773	64,090	4,271,863			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	120,032	30		9
10	Interest and Other Investment Income	(12,457)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(178)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(1,118)	21		18
19	Entertainment	(614)	20		19
20	Contributions	(2,000)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(64,000)	21		24
25	Fund Raising, Advertising and Promotional	(3,562)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(130,086)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (93,982)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	158,072		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 158,072		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 64,090		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

WINFIELD HEALTHCARE CENTER

ID# 0042333

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	R&M - CAPITALIZED	$ (114,446)	06	1
2	LEGAL - NON-ALLOW.	(7,084)	19	2
3	ILLINOIS COUNCIL LTC -COPE	(2,483)	20	3
4	R.O. PROFESSIONAL FEES	(2,500)	19	4
5	AUTO - NON-ALLOW.	(1,368)	35	5
6	MISC. INCOME	(4,245)	21	6
7	R.O. REPLACEMENT TAX	2,433	21	7
8	V.A. MEDICAL EXPENSES	(393)	10	8
9				9
10				10
11				11
12				12
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(178)											(178)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities													5
6	Maintenance	(114,446)											(114,446)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(114,624)											(114,624)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(393)											(393)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(393)											(393)	16
	C. General Administration													
17	Administrative													17
18	Directors Fees													18
19	Professional Services	(9,584)	2,500										(7,084)	19
20	Fees, Subscriptions & Promotions	(8,659)											(8,659)	20
21	Clerical & General Office Expenses	(66,930)	1										(66,929)	21
22	Employee Benefits & Payroll Taxes													22
23	Inservice Training & Education													23
24	Travel and Seminar													24
25	Other Admin. Staff Transportation													25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*													27
28	**TOTAL General Administration**	(85,173)	2,501										(82,672)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(200,189)	2,501										(197,688)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	120,032	184,125										304,157	30
31	Amortization of Pre-Op. & Org.		2,393										2,393	31
32	Interest	(12,457)	334,053										321,596	32
33	Real Estate Taxes													33
34	Rent-Facility & Grounds		(365,000)										(365,000)	34
35	Rent-Equipment & Vehicles	(1,368)											(1,368)	35
36	Other (specify):*													36
37	TOTAL Ownership	106,207	155,571										261,778	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(93,982)	158,072										64,090	45

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
DONALD SIMONSEN	99%	LYDIA HEALTHCARE	ROBBINS	WINFIELD BLDG	WINFIELD	BUILDING CO.
SUSAN SIMONSEN	1%			PARTNERSHIP		
				LLC		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rental Income	$ 365,000	WINFIELD BUILDING PARTNERSHIP	100.00%	$	$ (365,000)	1
2	V	33	Rental Income - R.E. Taxes	47,185				(47,185)	2
3	V	32	Interest Expense - Mortgage				336,639	336,639	3
4	V	32	Interest Expense-Auto Lease				537	537	4
5	V	33	Real Estate Taxes				47,600	47,600	5
6	V	33	Real Estate Taxes - Prior Year	415				(415)	6
7	V	30	Depreciation				184,125	184,125	7
8	V	31	Amortization				2,393	2,393	8
9	V	19	Professional Fees				2,500	2,500	9
10	V	21	Other				1	1	10
11	V	32	Interest Income	3,123				(3,123)	11
12	V	21	Replacement Taxes						12
13	V								13
14	Total			$ 415,723			$ 573,795	$ * 158,072	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	ARNOLD SIMONSEN	Executive Director	Administrative	99.00%	See Attached	10	25.00%	Mgmt Fees	$ 359,463	17-3	1
2	SUSAN SIMONSEN	Administrator	Administrative	1.00%	See Attached	40	80.00%	Salary	91,337	17-1	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 450,800		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
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14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
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2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
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14										14
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19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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Name of Related Organization
Street Address
City / State / Zip Code
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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
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4										4
5										5
6										6
7										7
8										8
9										9
10										10
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16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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Name of Related Organization
Street Address
City / State / Zip Code
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Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
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8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

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Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
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4										4
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9										9
10										10
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
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4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
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17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

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Name of Related Organization
Street Address
City / State / Zip Code
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	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
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14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	AMERICAN NAT'L BANK		X	MORTGAGE	$39,695	12/9/98	$ 5,200,000	$ 4,723,329			$ 336,639	1
2	CHEVY VAN		X	AUTO LEASE			33,134	10,795			537	2
3												3
4												4
5												5
	Working Capital											
6	DUE TO LYDIA BUILDING	X						629,254				6
7												7
8												8
9	TOTAL Facility Related				$39,695		$ 5,233,134	$ 5,363,378			$ 337,176	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(15,580)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (15,580)	14
15	TOTALS (line 9+line14)						$ 5,233,134	$ 5,363,378			$ 321,596	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	INTEREST INCOME- BLDG	X					$	$			$ (3,123)	1
2	INTEREST INCOME		X								(12,457)	2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (15,580)	21

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 43,600	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 43,185	2
3. Under or (over) accrual (line 2 minus line 1).		$ (415)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 47,600	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 47,185	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	41,244	8
	1997	39,389	9
	1998	42,884	10
	1999	42,267	11
	2000	43,185	12

R.E. TAX ACCRUAL = $43,185 X 1.02 = $47,600

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WINFIELD HEALTHCARE CENTER COUNTY DUPAGE

FACILITY IDPH LICENSE NUMBER 0042333

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,991 B. General Construction Type: Exterior BRICK Frame BRICK Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 2,393
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	20,991		$ 276,000	1
2					2
3	TOTALS	20,991		$ 276,000	3

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4				1996	$ 3,001,500	$	35	$ 150,075	$ 150,075	$ 812,906	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1996	19,219		20	963	963	5,015	9
10	Various			1997	1,556,040		20	77,804	77,804	380,870	10
11								-		-	11
12								-		-	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		-	-		-		-	68
69	Financial Statement Depreciation			184,125			(184,125)		69
70	TOTAL (lines 4 thru 69)		$ 4,576,759	$ 184,125		$ 228,842	$ 44,717	$ 1,198,791	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 4,576,759	$ 184,125		$ 228,842	$ 44,717	$ 1,198,791	1
2	ARCHITECT	1998	353		20	18	18	72	2
3	ARCHITECT	1998	300		20	15	15	59	3
4	SEXAUER	1998	3,009		20	150	150	600	4
5	HEPA FILETER/EXHAUST	1998			20				5
6	ARCHITECT	1998	184		20	9	9	35	6
7	SEXAUER	1998	1,517		20	76	76	304	7
8	ARCHITECT	1998	148		20	7	7	26	8
9	PLUMBING	1998	2,054		20	103	103	395	9
10	HEPA FILETER/EXHAUST	1998	10,948		20	547	547	2,188	10
11	REMODELING NORTH WIN	1998	3,522		20	176	176	675	11
12	DUMPSTER RENTAL	1998	675		20	34	34	130	12
13	1ST FLR REMODELING	1998	45,402		20	2,270	2,270	8,891	13
14	HVAC SYSTEM	1998	10,000		20	500	500	1,958	14
15	GENERATOR RPRS	1998	1,208		20	60	60	230	15
16	SERVICE SINK	1998	743		20	37	37	145	16
17	REFRIGERATION SYS	1998	6,260		20	313	313	1,226	17
18	BLINDS	1998	3,525		20	176	176	689	18
19	PARKING LOT	1998	3,030		20	152	152	570	19
20	FIRE SYSTEM	1998	1,130		20	57	57	214	20
21	PANELS-BVG COUNTER	1998	4,398		20	220	220	807	21
22	ELECTRICAL RPRS	1998	3,479		20	174	174	638	22
23	CONCRETE RPR	1998	1,295		20	65	65	238	23
24	COUNTERS	1998	560		20	28	28	105	24
25	LANDSCAPING	1998	5,200		20	260	260	932	25
26	WALK IN REFRIG	1998	663		20	33	33	118	26
27	NORTH PATIO PLANTS	1998	101		20	5	5	18	27
28	NORTH PATIO PLANTS	1998	2,260		20	113	113	405	28
29	SIGNS	1998	499		20	25	25	88	29
30	PLUMBING RPRS	1998	7,920		20	396	396	1,419	30
31	DRAIN TILE	1998	3,376		20	169	169	620	31
32	STONE BASE	1998	1,600		20	80	80	280	32
33	NEW ROOF	1998	26,000		20	1,300	1,300	4,550	33
34	TOTAL (lines 1 thru 33)		$ 4,728,118	$ 184,125		$ 236,410	$ 52,285	$ 1,227,416	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 4,728,118	$ 184,125		$ 236,410	$ 52,285	$ 1,227,416	1
2	TILES	1998	597		20	30	30	103	2
3	HVAC CONSULTING	1998	3,600		20	180	180	615	3
4	ELEC REPAIRS	1998	7,122		20	356	356	1,276	4
5	CUBICAL CURTAINS	1998	2,827		20	141	141	470	5
6	NURSE CALL SYS RPR	1998	807		20	40	40	133	6
7	SIGNS	1998	2,300		20	115	115	383	7
8	ARCHITECTURES	1998	3,552		20	178	178	579	8
9	POWERTRON	1998	953		20	48	48	148	9
10	LAVATORY	1998	486		20	24	24	88	10
11	WALK IN REFRIG	1998			20				11
12	REMODEL DIETARY-HVAC	1998	10,000		20	500	500	1,875	12
13	REMODEL DIETARY-HVAC	1998	26,450		20	1,323	1,323	4,961	13
14	REMODEL DIETARY	1998	52,784		20	2,639	2,639	9,896	14
15	REMODEL DIETARY	1998	6,833		20	342	342	1,283	15
16	REMODELING NORTH WIN	1998	31,575		20	1,579	1,579	5,658	16
17	REMODELING NORTH WIN	1998	49,485		20	2,474	2,474	8,865	17
18	WINDOW TREATMENTS	1998	480		20	24	24	86	18
19	REPAIRS 1ST FLOOR	1999	5,815		20	291	291	849	19
20	ELEVATOR REPAIRS	1999	1,625		20	81	81	223	20
21	TOILET KIT	1999	1,130		20	57	57	157	21
22	1ST FLOOR REPAIRS	1999	1,449		20	72	72	204	22
23	HVAC REPAIRS	1999	1,106		20	55	55	142	23
24	HVAC REPAIRS	1999	1,029		20	51	51	132	24
25	LUMBER	1999	1,784		20	89	89	237	25
26	BLINDS	1999	2,079		20	104	104	225	26
27	SPRINKLER SYSTEM	1999	6,550		20	328	328	683	27
28	BLINDS	1999			20				28
29	ROBERTS	1999	32,181		20	1,609	1,609	3,486	29
30	HVAC REPAIRS	1999			20				30
31	TRICOM-WIRING	1999	1,286		20	64	64	155	31
32	ROBERTS	1999	2,890		20	145	145	326	32
33	PLUMBING	1999	1,934		20	97	97	194	33
34	TOTAL (lines 1 thru 33)		$ 4,988,827	$ 184,125		$ 249,446	$ 65,321	$ 1,270,848	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 4,988,827	$ 184,125		$ 249,446	$ 65,321	$ 1,270,848	1
2	OLYMPIC SIGNS	1999	581		20	29	29	58	2
3	CORNICE & BLINDS INS	2000	1,294		20	65	65	130	3
4	BLINDS FREIGHT	2000	55		20	3	3	6	4
5	IDPH PERMIT FEE	2000	5,760		20	288	288	504	5
6	SEALCOATING & STRIPE	2000	3,998		20	200	200	333	6
7	GAS LEAK REPAIR	2000	582		20	29	29	58	7
8	ELECTRIC WORK	2000	606		20	30	30	60	8
9	GLASS/FRAME INST	2000	700		20	35	35	64	9
10	WINDOW INSTALLATION	2000	790		20	40	40	73	10
11	A/C REPAIR	2000	516		20	26	26	46	11
12	W/I FREEZER REPAIR	2000	535		20	27	27	47	12
13	PLUMBING	2000	920		20	46	46	58	13
14	CABLE & JACK INST	2000	940		20	47	47	51	14
15	COUNTER TOP INST	2000	500		20	25	25	27	15
16	PLUMBING	2000	11,715		20	586	586	1,123	16
17	VENTILATION	2000	2,898		20	145	145	278	17
18	PLUMBING	2000	1,869		20	93	93	163	18
19	REMODELING	2000	1,700		20	85	85	156	19
20	REMODELING	2000	1,700		20	85	85	156	20
21	A/C TEST & BALANCE	2000	8,500		20	793	793	1,360	21
22	SPRINKLER INST	2000	3,000		20	150	150	175	22
23	SHELVES INSTALLATION	2000	600		20	30	30	35	23
24	FIRE DOOR	2000	2,100		20	105	105	175	24
25	FLOORING	2000	2,100		20	105	105	175	25
26	BLDG DEMOLITION	2000	13,500		20	675	675	788	26
27	BORDER	2001	3,276		20	137	137	137	27
28	BORDER,COVE BASE	2001	714		20	30	30	30	28
29	BORDER	2001	1,013		20	38	38	38	29
30	BORDER INS	2001	2,208		20	83	83	83	30
31	COVE BASE,WINDOW,CHA	2001	2,701		20	113	113	113	31
32	WALLPAPER	2001	162		20	7	7	7	32
33	WALLPAPER,BORDER,COV	2001	2,726		20	113	113	113	33
34	TOTAL (lines 1 thru 33)		$ 5,069,086	$ 184,125		$ 253,709	$ 69,584	$ 1,277,468	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 5,069,086	$ 184,125		$ 253,709	$ 69,584	$ 1,277,468	1
2	CORNER PIECE	2001	638		20	21	21	21	2
3	WALLPAPER	2001	525		20	17	17	17	3
4	BORDER	2001	263		20	9	9	9	4
5	BORDER	2001	89		20	3	3	3	5
6	WALLPAPER	2001	491		20	21	21	21	6
7	BORDER	2001	156		20	4	4	4	7
8	BORDER INSTALL	2001	415		20	11	11	11	8
9	LABOR STRIP	2001	667		20	17	17	17	9
10	LABOR - BORDER,STRIP	2001	1,357		20	34	34	34	10
11	WALL BUMPERS	2001	331		20	7	7	7	11
12	CARPET	2001	5,087		20	64	64	64	12
13	CARPETING	2001	1,441		20	18	18	18	13
14	COVE BASE	2001	524		20	4	4	4	14
15	FLOOR PATCH	2001	170		20	2	2	2	15
16	ROSEWOOD WING CORRID	2001	15,186		20	63	63	63	16
17	CONSTRUCTION	2001	2,415		20	20	20	20	17
18	CONDENSOR MOTOR	2001	688		20	23	23	23	18
19	ALARM INSTALLATION	2001	7,073		20	354	354	354	19
20	HVAC	2001	7,547		20	346	346	346	20
21	SPRINKLERS INSTALL	2001	37,000		20	1,850	1,850	1,850	21
22	PLUMBING & SEWER WOR	2001	5,089		20	212	212	212	22
23	ELEC LABOR & MATERIA	2001	1,250		20	47	47	47	23
24	CARY SUPPLY	2001	1,810		20	61	61	61	24
25	SPRINKLERS	2001	16,250		20	678	678	678	25
26	PLUMBING	2001	1,756		20	59	59	59	26
27	A/C WORK	2001	9,543		20	278	278	278	27
28	5 EXHAUST FAN BRACKE	2001	1,163		20	10	10	10	28
29	EXHAUST FAN MOTORS	2001	1,402		20	12	12	12	29
30	BLOWER MOTORS	2001	1,481		20	12	12	12	30
31	BORDER	2001	5,476		20	274	274	274	31
32	LAUNDRY RM EXHAUST F	2001	2,930		20	12	12	12	32
33	CYLINDER CORES	2001	833		20	42	42	42	33
34	TOTAL (lines 1 thru 33)		$ 5,200,132	$ 184,125		$ 258,294	$ 74,169	$ 1,282,053	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 5,200,132	$ 184,125		$ 258,294	$ 74,169	$ 1,282,053	1
2	ALARM INSTALLATION	2001	7,155		20	358	358	358	2
3	HEATING/AIRCONDITION	2001	36,000		20	1,800	1,800	1,800	3
4	BORDER INS	2001	1,725		20	57	57	57	4
5	TEST & BALANCE ENV.	2001	8,500		20	106	106	106	5
6	DUCT REVISION	2001	6,500		20	81	81	81	6
7	THERMOSTATS	2001	765		20	35	35	35	7
8	WRIGHT ELECTRIC	2001	500		20	23	23	23	8
9	PLUMBING & SEWER	2001	676		20	26	26	26	9
10	PLUMBING & SEWER	2001	717		20	15	15	15	10
11	MOTOR	2001	925		20	15	15	15	11
12	MOTOR	2001	703		20	12	12	12	12
13	NETWORKING SOLUTIONS	2001	813		20	3	3	3	13
14	WALLPAPER	2001	655		20	3	3	3	14
15	HEATING IMPROVEMENT	2001	532		20	2	2	2	15
16	ELEVATOR	2001	6,600		20	275	275	275	16
17	WRIGHT ELECTRIC	2001	500		20	23	23	23	17
18	ELEVATOR RENOVATION	2001	1,455		20	49	49	49	18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,274,853	$ 184,125		$ 261,177	$ 77,052	$ 1,284,936	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 5,274,853	$ 184,125		$ 261,177	$ 77,052	$ 1,284,936	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,274,853	$ 184,125		$ 261,177	$ 77,052	$ 1,284,936	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 5,274,853	$ 184,125		$ 261,177	$ 77,052	$ 1,284,936	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,274,853	$ 184,125		$ 261,177	$ 77,052	$ 1,284,936	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 5,274,853	$ 184,125		$ 261,177	$ 77,052	$ 1,284,936	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 5,274,853	$ 184,125		$ 261,177	$ 77,052	$ 1,284,936	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$	$		$	$	$	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 368,175	$	$ 36,443	$ 36,443	10	$ 185,525	71
72	Current Year Purchases	50,810		3,539	3,539	10	3,539	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 418,985	$	$ 39,982	$ 39,982		$ 189,064	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		99 CHEVY VAN	1999	$ 27,374	$	$ 2,950	$ 2,950	5	$ 11,010	76
77		SATURN	2001	5,760		48	48	5	48	77
78										78
79										79
80	TOTALS			$ 33,134	$	$ 2,998	$ 2,998		$ 11,058	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 6,002,972	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 184,125	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 304,157	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 120,032	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,485,058	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 4,864 Description: Water Cooler $1,356, Plant Rental $2,368, Water Conditioner $1,140.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	BUSINESS	2000 Mercedes-Benz	$ 826	$ 13,571	17
18					18
19					19
20					20
21	TOTAL		$ 826	$ 13,571	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 311,569	$ 357,565	1
2	Cash-Patient Deposits	21,713	21,713	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	857,725	857,725	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	3,278	3,278	6
7	Other Prepaid Expenses	27,000	27,000	7
8	Accounts Receivable (owners or related parties)	(689,627)		8
9	Other(specify): See supplemental schedule			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 531,658	$ 1,267,281	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		289,500	13
14	Buildings, at Historical Cost		3,001,500	14
15	Leasehold Improvements, at Historical Cost		2,052,969	15
16	Equipment, at Historical Cost		467,669	16
17	Accumulated Depreciation (book methods)		(1,031,011)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See supplemental schedule		9,373	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 4,790,000	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 531,658	$ 6,057,281	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 86,635	$ (10,763)	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	21,713	21,713	28
29	Short-Term Notes Payable		640,049	29
30	Accrued Salaries Payable	179,990	179,990	30
31	Accrued Taxes Payable (excluding real estate taxes)		(2,370)	31
32	Accrued Real Estate Taxes(Sch.IX-B)		47,600	32
33	Accrued Interest Payable		27,553	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	8,962	8,962	35
	Other Current Liabilities(specify):			
36	See supplemental schedule	14,000	14,000	36
37		471,779	471,779	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 783,079	$ 1,398,513	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,723,329	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,723,329	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 783,079	$ 6,121,842	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (251,421)	$ (64,561)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 531,658	$ 6,057,281	48

*(See instructions.)

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (378,905)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (378,905)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	127,484	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 127,484	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (251,421)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,318,555	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,318,555	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	12,457	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 12,457	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	4,245	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,245	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,335,257	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,167,179	31
32	Health Care	1,418,029	32
33	General Administration	1,122,139	33
	B. Capital Expense		
34	Ownership	431,988	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	68,438	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,207,773	40
41	**Income before Income Taxes (line 30 minus line 40)****	127,484	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 127,484	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,469	1,636	$ 53,390	$ 32.63	1
2	Assistant Director of Nursing					2
3	Registered Nurses	10,989	12,076	279,933	23.18	3
4	Licensed Practical Nurses	11,877	12,673	254,336	20.07	4
5	Nurse Aides & Orderlies	36,718	41,087	519,538	12.64	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	7,210	7,601	85,100	11.20	10
11	Social Service Workers	7,755	8,335	125,466	15.05	11
12	Dietician					12
13	Food Service Supervisor	470	646	9,786	15.15	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,950	17,950	155,190	8.65	15
16	Dishwashers					16
17	Maintenance Workers	1,542	1,565	20,396	13.03	17
18	Housekeepers	26,805	28,945	240,394	8.31	18
19	Laundry	3,299	3,779	29,718	7.86	19
20	Administrator	840	1,040	91,337	87.82	20
21	Assistant Administrator	777	834	16,789	20.13	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,216	1,342	24,436	18.21	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,582	1,739	22,333	12.84	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	132,499	141,248	$ 1,928,142 *	$ 13.65	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 8,565	01-03	35
36	Medical Director	Monthly	3,000	09-03	36
37	Medical Records Consultant	154	2,849	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,100	10-03	39
40	Physical Therapy Consultant	65	3,228	10a-03	40
41	Occupational Therapy Consultant	Monthly	1,968	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	315	10,077	11-03	44
45	Social Service Consultant	236	7,531	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	770	$ 38,318		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	73	$ 3,167	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	73	$ 3,167		53

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SUSAN SIMONSEN	ADMINISTRATOR	1%	$ 91,337
Jan. thru June 2001			
NIQUITTA BEERY	Ass't Administrator	0%	16,789
July 2001 thru Dec. 2001			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 108,126

B. Administrative - Other

Description	Amount
ARNOLD SIMONSEN - MANAGEMENT FEES	$ 359,463
DEBBIE WALKER - CONSULTANT ADMINISTRATOR	23,970
TOTAL (agree to Schedule V, line 17, col. 3)	$ 383,433
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
LEVENFELD PEARLSTEIN	LEGAL-Adjust Out p. 5	$ 7,084
FR&R TECHNOLOGY SERV.	DATA PROCESSING	8,999
PERSONNEL PLANNERS	UNEMPLOYMENT CLST	1,251
PAYCHEX	PAYROLL PROCESSING	7,085
ECONOCARE	PURCHASING	1,265
FR&R	ACCOUNTING	43,209
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 68,892

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 50,953
Unemployment Compensation Insurance	43,380
FICA Taxes	127,819
Employee Health Insurance	83,675
Employee Meals	7,775
Illinois Municipal Retirement Fund (IMRF)*	
Employee Welfare	26,842
Employee Benefits	6,065
TOTAL (agree to Schedule V, line 22, col.8)	$ 346,509

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	22,854
Health Care Worker Background Check	
(Indicate # of checks performed)	
Licenses and Fees	4,313
Dues & Subscriptions	5,330
Advertising & Promotion	3,562
Less: Public Relations Expense	
Non-allowable advertising	(3,562)
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 32,897

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,195
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,195

**See instructions.

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2	N/A												
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WINFIELD HEALTHCARE CENTER # 0042333 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **Illinois Council LTC $4,574**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YEARS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **68,438**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **7,775** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **N/A**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees